

**STATEMENT OF VISION****NOT VALID AFTER 90 DAYS FROM EXAMINATION DATE**

(Applicant completes before doctor's exam.)

By this form, or copy thereof, I hereby authorize and request the examining doctor to provide any information regarding my visual condition and history to the Department of Motor Vehicles, State of Nebraska.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Applicant's Signature)

I hereby certify that I examined the eyes of \_\_\_\_\_  
(Applicant's Name)

of \_\_\_\_\_  
(Street Address) (City) (Zip Code)

Date of Birth \_\_\_\_\_ License Number \_\_\_\_\_

To be completed by optometrist or ophthalmologist.

1. Unaided acuity: Both \_\_\_\_\_ Left Eye \_\_\_\_\_ Right Eye \_\_\_\_\_

2. a. Best correctable acuity: Both \_\_\_\_\_ Left Eye \_\_\_\_\_ Right Eye \_\_\_\_\_

b. Visual acuity using telescopic lens:  $\frac{20}{\text{_____}}$   $\frac{20}{\text{_____}}$   $\frac{20}{\text{_____}}$   
Both Left Right

c. Visual acuity through carrier lens:  $\frac{20}{\text{_____}}$   $\frac{20}{\text{_____}}$   $\frac{20}{\text{_____}}$   
Both Left Right

d. Type of lenses used: Std. Spectacle \_\_\_\_\_ Aphakic \_\_\_\_\_  
Contact Lenses \_\_\_\_\_ Telescopic Lenses \_\_\_\_\_

3. Extent of entire horizontal form field, either binocular or monocular, as determined with a 330/5 mm Arc Perimeter or comparable instrument:

Left Eye: \_\_\_\_\_ Degrees Temporal Right Eye: \_\_\_\_\_ Degrees Temporal  
\_\_\_\_\_ Degrees Nasal \_\_\_\_\_ Degrees Nasal

Field of Vision looking through carrier lens: \_\_\_\_\_ ° Temp \_\_\_\_\_ ° Temp  
Left Right  
\_\_\_\_\_ ° Nasal \_\_\_\_\_ ° Nasal  
Left Right

4. Are new corrective lenses required? Yes \_\_\_\_\_ No \_\_\_\_\_

5. Diplopia: *(Check appropriate line.)*  
 \_\_\_\_\_ a. highly unlikely to occur  
 \_\_\_\_\_ b. intermittent\*      \*Please Explain: \_\_\_\_\_  
 \_\_\_\_\_ c. constant\*      \_\_\_\_\_
6. If best visual acuity is less than 20/40 in either eye or both, or total horizontal form field is less than 140 degrees, give cause and probable prognosis under Additional Comments.

**Answer questions #7 and #8 only for commercial motor vehicle operators.**

7. Based upon your examination, has the vision condition of this patient, which was in existence prior to July 30, 1996, significantly worsened or another condition developed? ☐ No ☐ Yes
- If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
8. Color blindness: Able to recognize the colors of traffic signals and devices showing standard red, green and amber. ☐ No ☐ Yes
9. In my opinion, this applicant should have their vision retested for driving purposes in \_\_\_\_ years.
10. **Date of eye examination:** \_\_\_\_\_  
 (MUST BE COMPLETED—STATEMENT OF VISION NOT VALID  
 AFTER 90 DAYS FROM EXAMINATION DATE.)

Additional Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Name of Optometrist or Ophthalmologist      Signature of Optometrist or Ophthalmologist\*  
 (Please Print)

\_\_\_\_\_  
 Address of Optometrist or Ophthalmologist (Please Print)

\_\_\_\_\_  
 Telephone Number of Optometrist or Ophthalmologist: (\_\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_  
 Fax Number of Optometrist or Ophthalmologist: (\_\_\_\_\_) \_\_\_\_\_

**\* If the applicant needs new corrective lenses to get the best correctable acuities listed on page 1, please delay signing this statement until the new lenses are in use by the applicant.**